New York
Plan Name: EPO
Plan Form: NY-EPO-SB-002
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$6,200 Person/$12,400 Family - Embedded	None
Co-insurance	30% coinsurance*	None
Annual Out-of-Pocket Maximum	$9,500 Person/$19,000 Family - Embedded	None
Primary Care Physician Office Visits	$35 copay*	First Three (3) visits Covered in full
Specialist Office Visits	$60 copay*	None
Preventive & Well Care Services		
Well Child Care & Immunizations	Covered in Full not subject to Deductible For a full list of covered preventive care services, visit mvphealthcare.com.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
Adult Annual Physical (One per Contract Year)		
Mammography		
Annual Pap Test & Ob/Gyn Exam		
Immunizations for Adults		
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits		
Diagnostic Laboratory Services	PCP: $35 copay*/Spec: $60 copay*	None
Diagnostic X-ray	PCP: $35 copay*/Spec: $60 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $60 copay*/Free-Stnd: $60 copay*	None
Rehabilitative Services (PT/OT/ST)	$60 copay*	54 visits per condition, per Plan Year combined therapies
Allergy Services	$60 copay*	
Chemotherapy Visit	$60 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	30% coinsurance*	Per continuous confinement
Surgical Services	30% coinsurance*	None
Inpatient Physical Rehabilitation	30% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehabilitation Services (PT/OT/ST)	$60 copay*	54 visits per condition, per Plan Year combined therapies
Diagnostic Laboratory Services ++	$60 copay*	None
Diagnostic X-ray ++	$60 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	$60 copay*	None
Ambulatory/Outpatient Surgery ++	$300 copay*	None
Infusion Therapy	$60 copay*	None
Emergency Care		
Emergency Room (ER) Visit	$350 copay*	None
Urgent Care Centers	$60 copay not subject to Deductible	None
Ambulance (Emergency Medical Transportation)	$350 copay*	None
Maternity Services		
Maternity – Prenatal Care Office Visit	Covered in Full not subject to Deductible	None
Maternity – Physician Delivery	30% coinsurance*	None
Maternity – Inpatient Hospital Services	30% coinsurance*	None
Behavioral Health Services		
Mental Health Inpatient Hospital	30% coinsurance*	Including residential treatment
Mental Health Outpatient	$35 copay*	First Three (3) visits Covered in full
Substance Use Disorder Inpatient Hospital	30% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	$35 copay*	First Three (3) visits Covered in full
Autism Treatment	$35 copay*	First Three (3) visits Covered in full
Assistive Communication Devices for Autism Spectrum Disorder	$35 copay*	None
Other Services		

*Deductible applies to this benefit

New York
Plan Name: EPO
Plan Form: NY-EPO-SB-002
Plan Status: Active

	Coverage Information	Limits and Exclusions
Physician Administered Drugs Outpatient	20% coinsurance*	None
Skilled Nursing Facility	30% coinsurance*	200 days per Plan Year
Home Health Care	$50 copay*	60 visits per Plan Year
Hospice	Inpt: 30% coinsurance*/Outpt: $50 copay*	210 days per Plan Year, Five (5) visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance*	None
Diabetic Supplies & Equipment	$35 copay*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$60 copay*	None
Acupuncture	50% coinsurance*	12 visits per Plan Year.
Home Infusion	$50 copay*	Home infusion counts toward home health care visit limits
Prescription Drug Coverage		
Tier 1 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $25 copay not subject to Deductible /Mail: $62.50 copay not subject to Deductible	30 day retail/90 day mail order
Tier 2 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $40 copay* /Mail: $100 copay*	30 day retail/90 day mail order
Tier 3 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $60 copay* /Mail: $150 copay*	30 day retail/90 day mail order
Ancillary Care		
Adult Vision Care	$60 copay*	None
Pediatric Vision Care	$60 copay*	None
Pediatric Dental	$25 copay not subject to Deductible	One (1) dental exam and cleaning per six (6) month period
Other Plan Features		
Gia® Virtual Care	Covered in Full not subject to Deductible	None
Wellness Benefits	Get reimbursed up to $600 per contract, per calendar year for expenses associated with activities, tools, and apps that enhance your overall well-being with MVP's Well-Being Reimbursement	
Doula Program	Get reimbursed up to $1,500 per plan year for doula expenses with MVP's Doula Reimbursement Program.	
Plan Highlights	Visit **mvphealthcare.com** for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.	
++Preferred Provider Facilities	Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after deductible (if applicable). Find a preferred provider facility in your area at mvphealthcare.com.	

This plan overview is intended to provide a general outline of coverage. In the event of any conflict between this document and your Certificate of Coverage (COC), Schedule, and any applicable Rider(s), your COC, Schedule, and Rider(s) will be controlling. For plan details, please call **1-800-TALK-MVP** (825-5687), or visit **mvphealthcare.com**.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans are available in all states and counties.

*Deductible applies to this benefit

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, visit mvphealthcare.com or by calling 1-888-687-6277 For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call **1-888-687-6277** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6,200 individual / $12,400 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$9,500 individual / $19,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance billing charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See mvphealthcare.com or call 1-888-687-6277 for a list of network providers	You pay the least if you use a provider in the Preferred Provider tier. You pay more if you use a provider in the In-Network tier. You will pay the most if you use an Out-of-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	NA	$35 copay/office visit Deductible applies	Not covered	First Three (3) visits Covered in full
	Specialist visit	NA	$60 copay/visit Deductible applies	Not covered	None
	Preventive care/screening/immunization	No charge Deductible does not apply	No charge Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Facility – $0 copay/visit Deductible applies; Radiology Facility – $0 copay/visit Deductible applies	Lab Office – PCP: $35 copay/visit Deductible applies & Spec: $60 copay/visit Deductible applies; Lab Facility – $60 copay/visit Deductible applies; Radiology Office – PCP: $35 copay/visit Deductible applies & Spec: $60 copay/visit Deductible applies; Radiology Facility – $60 copay/visit Deductible applies	Lab Office – PCP & Spec: Not covered; Lab Facility – Not covered; Radiology Office – PCP & Spec: Not covered; Radiology Facility – Not covered	Lab Office – PCP: None & Spec: None; Lab Facility – None; Radiology Office – PCP: None & Spec: None; Radiology Facility – None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	Facility – $0 copay/procedure Deductible applies	Office – $60 copay/procedure Deductible applies; Facility – $60 copay/procedure Deductible applies	Office – Not covered; Facility – Not covered	Office – None; Facility – None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **mvphealthcare.com**	Tier 1 (Generic drugs)	NA	Retail $25 copay/prescription Deductible does not apply; Mail Order $62.50 copay/prescription Deductible does not apply	Retail Not covered; Mail Order Not covered	30 day retail/90 day mail order;
	Tier 2 (Preferred brand drugs)	NA	Retail $40 copay/prescription Deductible applies; Mail Order $100 copay/prescription Deductible applies	Retail Not covered; Mail Order Not covered	30 day retail/90 day mail order;
	Tier 3 (Non-preferred brand drugs)	NA	Retail $60 copay/prescription Deductible applies; Mail Order $150 copay/prescription Deductible applies	Retail Not covered; Mail Order Not covered	30 day retail/90 day mail order;
	Tier 4 (Specialty drugs)	NA	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes; Mail Order Deductible applies	Not Covered	Covered as noted generic, preferred, and non-preferred

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copay/day Deductible applies	$300 copay/day Deductible applies	Not covered	None
	Physician/surgeon fees	NA	$50 copay Deductible applies	Not covered	None
If you need immediate medical attention	Emergency room care	NA	$350 copay/visit Deductible applies	$350 copay/visit Deductible applies	None
	Emergency medical transportation	NA	$350 copay/trip Deductible applies	$350 copay/trip Deductible applies	None
	Urgent care	NA	$60 copay/visit Deductible does not apply	$60 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	NA	30% coinsurance Deductible applies	Not covered	Per continuous confinement
	Physician/surgeon fees	NA	30% coinsurance Deductible applies	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	NA	$35 copay/visit Deductible applies	Not covered	First Three (3) visits Covered in full
	Inpatient services	NA	30% coinsurance Deductible applies	Not covered	Including residential treatment
If you are pregnant	Office visits	NA	No charge Deductible does not apply	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay, coinsurance,

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	NA	30% coinsurance Deductible applies	Not covered	and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	NA	30% coinsurance Deductible applies	Not covered	
If you need help recovering or have other special health needs	Home health care	NA	$50 copay/visit Deductible applies	Not covered	60 visits per Plan Year
	Rehabilitation services/Habilitation services	NA	OP ReHab: $60 copay/visit Deductible applies IP ReHab: 30% coinsurance Deductible applies	OP ReHab: Not covered IP ReHab: Not covered	OP ReHab: 54 visits per condition, per Plan Year combined therapies IP ReHab: 60 days per Plan Year Combined Therapies
	Skilled nursing care	NA	30% coinsurance Deductible applies	Not covered	200 days per Plan Year
	Durable medical equipment	NA	50% coinsurance Deductible applies	Not covered	Standard equipment covered
	Hospice services	NA	30% coinsurance Deductible applies	Not covered	210 days per Plan Year, Five (5) visits for family bereavement counseling
If your child needs dental or eye care	Children's eye exam	NA	$60 copay/exam Deductible applies	Not covered	One (1) exam per 12-month period
	Children's glasses	NA	50% coinsurance Deductible applies	Not covered	One (1) Prescribed Standard Lenses & Frames in a 12-Month Period.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	NA	$25 copay/visit Deductible does not apply	$25 copay/visit Deductible does not apply	One (1) dental exam and cleaning per six (6) month period

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

MVP Health Care
P.O. Box 2207
Schenectady, NY 12301
Toll Free: 1-888-687-6277
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800- 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

MVP Health Care
Attn: Member Appeals
P.O.Box 2207
Schenectady, NY 12301
Toll Free:1-888-687-6277
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the NYS Department of Insurance at 1-800-342-3736 or dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Health Advocates at 1-888-614-5400 or communityhealthadvocates.org.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	$6,200
■ Specialist copayment	$60
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,200
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,170**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$6,200
■ Specialist copayment	$60
■ Hospital (facility) coinsurance	30%
■ Other copayment	$35

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter))*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,100
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,220**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	$6,200
■ Specialist copayment	$60
■ Hospital (facility) coinsurance	30%
■ Other copayment	$350

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,810**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$400
The total Mia would pay is	**$2,810**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call **1-844-946-8010** (TTY 711).	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al **1-844-946-8010** (TTY 711).	**Español (Spanish)**
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 **1-844-946-8010** (TTY 711)。	繁體中文 **(Chinese)**
ملاحظة: **1-844-946-8010** خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم (TTY 711).	لعربية **(Arabic)**
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다 **1-844-946-8010** (TTY 711). 번으로 연락해 주십시오.	한국어 **(Korean)**
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру **1-844-946-8010** (TTY 711).	Русский **(Russian)**
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il **1-844-946-8010** (TTY 711).	**Italiano (Italian)**
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le **1-844-946-8010** (TTY 711).	**Français (French)**
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele **1-844-946-8010** (TTY 711).	**Kreyòl Ayisyen (French Creole)**
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט **1-844-946-8010** (TTY 711).	**אידיש (Yiddish)**
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: **1-844-946-8010** (TTY 711).	**Polski (Polish)**
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa **1-844-946-8010** (TTY 711).	**Tagalog (Tagalog-Filipino)**
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। **1-844-946-8010** (TTY 711.-এ ফোন করুন।	**বাংলা** (Bengali)
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi **1-844-946-8010** (TTY 711).	**Shqip (Albanian)**
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο **1-844-946-8010** (TTY 711).	Ελληνικά **(Greek)**
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں **1-844-946-8010** (TTY 711). کریں	اردو **(Urdu)**

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